Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Downtown Performance Medical Center
3033 Fannin
Houston, TX 77004

MFDR Tracking #: M4-07-4237-01

Respondent Name and Box #:

Old Republic Insurance Co.
Rep. Box #: 42

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCU

Requestor's Position Summary taken from the Table of Disputed Services: "Carrier did not respond to request for reconsideration."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $30.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Response not submitted.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

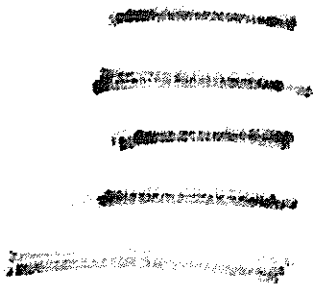
Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/13/06 & 12/11/06	CPT Code 99080-73 ($15.00 x 2)	W9	1, 2	$30.00
Total Due:				$30.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

* CPT Code 99213 for dates of service 11/13/06 and 12/11/06 were denied as "W9 – Unnecessary medical treatment based on peer review." The Requestor was contacted by Medical Fee Dispute Resolution and they withdrew the disputed CPT Code.

1. These services were denied by the Respondent with reason code "W9 – Unnecessary medical treatment based on peer review."



2. CPT Code 99080-73 is a code specific to Division of Workers' Compensation and not subject to medical necessity review. Per Division Rule at 28 Texas Administrative Code Section 129.5(i) reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

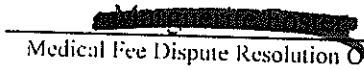
Texas Labor Code Section. 413.011(a-d). Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 129.5. Section 134.1
Texas Government Code. Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $30.00 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature



Medical Fee Dispute Resolution Officer

April 10, 2008
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.